This is a sample form and may be modified as necessary.

HEALTH-CARE-ASSOCIATED INFECTION WORKSHEET

PATIENT NAME: _____ RANK/STATUS:_____

SOCIAL SECURITY #: _____ PHONE #:_____

ORGANIZATION/ADDRESS: _____

PATIENT AGE: _____

DATE OF PROCEDURE: _____

TYPE OF PROCEDURE: _____

WOUND CLASSIFICATION: _____

PROVIDER(S): _____

DATE INFECTION DIAGNOSED: _____

DESCRIPTION OF THE INFECTION: _____
_____
_____
_____

CULTURE OBTAINED: yes or no

CULTURE RESULTS (if applicable): _____

TREATMENT RENDERED (including any antibiotic prescriptions):
_____
_____
_____

REPORTED BY: _____ DATE REPORTED: _____

FOLLOW-UP: _____
_____
_____
_____
_____